INFLUENZA-ASSOCIATED DEATHS CASE INVESTIGATION - Page 1 of 4

Indiana State Department of Health
State Form 52576 (2-06)

DIRECTIONS - PLEASE READ BEFORE YOU BEGIN:

1. Print firmly and neatly.
2. Only use pens with blue or black ink.
3. Fill in circles like this: ● Not like this: ⊗ ✓ Mark mistakes like this: ●
4. Print capital letters only and numbers completely inside boxes. A 2 C 3
5. Please complete all items on form.
6. **Date format: MM/DD/YY**

Section 1. Demographic Information

Last Name | **ISDH Action:** ○ A case ○ Not a case

First Name | **MI** | **Phone Number** ___ - ___ - ____

Number & Street Address

City | **State** | **ZIP Code** ____ - ____

County | **Date of Birth** __ / __ / ____ | **Age**

Race:
- ○ Asian
- ○ Black or African American
- ○ American Indian or Alaska Native
- ○ Native Hawaiian or Other Pacific Islander
- ○ White
- ○ Other/Multiracial
- ○ Unknown

Ethnicity: ○ Hispanic or Latino ○ Not Hispanic or Latino ○ Unknown

Sex: ○ Male ○ Female ○ Unknown

Is Age in day/mo/yr? ○ Days ○ Months ○ Years

Occupation | **Phone of Employer/School/Day Care** ___ - ___ - ____

Name of ○ Employer ○ School ○ Day Care

Address of Employer/School/Day Care

City | **State** | **ZIP Code** ____ - ____

Section 2. Clinical Information

Date of Illness Onset __ / __ / __ | **Date of Death** __ / __ / __ | **Was an autopsy performed?** ○ Yes ○ No

Location of Death: ○ Home ○ Emergency Department (ED) ○ Inpatient Ward ○ ICU ○ Other

If Other, specify

Hospital/Institution Name

Hospital/Institution Address

City | **State** | **ZIP Code** ____ - ____

Hospital/Institution Phone ___ - ___ - ____

Indiana State Department of Health
State Form 52576 (2-06)

Section 2. Clinical Information (continued)

Influenza Testing (check all that were used):

Test Type	Results		Specimen Collection Date
○ Commercial Rapid Antigen/ Diagnostic Test	○ Influenza A ○ Influenza B	○ Influenza A/B (not distinguished) ○ Negative	__/__/__
○ Viral Culture	○ Influenza A (subtyping not done) ○ Influenza A (unable to subtype) ○ Influenza B	○ Influenza A (H1) ○ Influenza A (H3) ○ Negative	__/__/__
○ Direct Florescent Antibody (DFA)	○ Influenza A ○ Influenza B	○ Influenza A/B ○ Negative	__/__/__
○ Indirect Florescent Antibody (IFA)	○ Influenza A ○ Influenza B	○ Influenza A/B ○ Negative	__/__/__
○ Enzyme Immunoassay (EIA)	○ Influenza A (subtyping not done) ○ Influenza A (unable to subtype) ○ Influenza B	○ Influenza A (H1) ○ Influenza A (H3) ○ Negative	__/__/__
○ RT-PCR	○ Influenza A (subtyping not done) ○ Influenza A (unable to subtype) ○ Influenza B	○ Influenza A (H1) ○ Influenza A (H3) ○ Negative	__/__/__
○ Immunohistochemistry(IHC)	○ Influenza A	○ Influenza B / ○ Negative	__/__/__

Was an INVASIVE bacterial infection confirmed by culturing an organism from a normally sterile site (e.g., blood, cerebrospinal fluid (CSF), tissue, or pleural fluid)?

○ Yes ○ No

If Yes, check all that apply:

- ○ *Streptococcus pneumoniae*
- ○ *Haemophilus influenzae* (type b)
- ○ *Haemophilus influenzae* (not type b)
- ○ Group A *Streptococcus* (GAS)
- ○ Other Invasive Bacteria: _____
- ○ *Staphylococcus aureus,* Methicillin Sensitive
- ○ *Staphylococcus aureus,* Methicillin Resistant (MRSA)
- ○ *Staphylococcus aureus* (sensitivity not done)
- ○ *Neisseria meningitidis* (serogroup, if known) _____

Did the patient receive medical care for this illness?

○ Yes ○ No **If Yes, date:** __/__/__

If Yes, indicate level(s) of care received (check all that apply):

○ Outpatient Clinic ○ Emergency Department (ED) ○ Inpatient Ward ○ ICU

If Yes, did the patient require mechanical ventilation?

○ Yes ○ No

Check all complications that occurred during the acute illness:

- ○ None
- ○ Pneumonia (chest x-ray confirmed)
- ○ Bronchiolitis
- ○ Other Complications: _____
- ○ Acute Respiratory Disease Syndrome (ARDS)
- ○ Encephalopathy/Encephalitis
- ○ Seizures
- ○ Croup
- ○ Reye's Syndrome
- ○ Shock

Indiana State Department of Health
State Form 52576 (2-06)

Section 3. Risk Factors

Check all medical conditions that existed before onset of the acute illness:

- ○ Moderate to Severe Developmental Delay
- ○ Hemaglobinopathy (e.g., sickle cell disease)
- ○ Asthma/Reactive Airway Disease
- ○ Diabetes Mellitus
- ○ History of Febrile Seizures
- ○ Seizure Disorder
- ○ Cystic Fibrosis
- ○ Cardiac Disease, specify: _____
- ○ Renal Disease, specify: _____
- ○ Chronic Pulmonary Disease, specify: _____
- ○ Immunosuppressive Condition, specify: _____
- ○ Metabolic Disorder, specify: _____
- ○ Neuromuscular Disorder (including cerebral palsy), specify: _____
- ○ Pregnant, specify gestational age: ____ weeks
- ○ Other, specify: _____

Was the patient receiving any of the following therapies prior to illness onset (check all that apply)?

- ○ Aspirin or Aspirin-containing Products
- ○ Chemotherapy Treatment for Cancer
- ○ Any Other Immunosuppressive Therapy: _____
- ○ Steroids Taken by Mouth or Injection
- ○ Radiation Therapy

Did the patient receive any influenza vaccine during the current season (before illness)?

○ Yes ○ No

If Yes, please specify influenza vaccine received before illness onset:

- ○ Trivalent Inactivated Influenza Vaccine (TIV) Injected
- ○ Live-Attenuated Influenza Vaccine (LAIV) Nasal Spray

If Yes, how many doses did the patient receive and what was the timing of each dose?

- ○ 1 Dose ONLY
  - ○ < 14 days prior to illness onset
  - ○ ≥ 14 days prior to illness onset
  - **Date dose given** ____ / ____ / ____
- ○ 2 Doses
  - ○ < 14 days prior to illness onset
  - ○ ≥ 14 days prior to illness onset
  - **Date 1st dose given** ____ / ____ / ____ **Date 2nd dose given** ____ / ____ / ____

Did the patient travel outside the county of residence but within Indiana?

○ Yes ○ No ○ Unknown

_____

If Yes, where

____ / ____ / ____ **Date of departure** ____ / ____ / ____ **Date of return**

Did the patient travel outside of Indiana?

○ Yes ○ No ○ Unknown

_____

If Yes, where

____ / ____ / ____ **Date of departure** ____ / ____ / ____ **Date of return**

Indiana State Department of Health
State Form 52576 (2-06)

Section 3. Risk Factors (continued)

Did the patient raise or have contact with poultry or waterfowl?

○ Yes ○ No ○ Unknown

If Yes, describe

Location

Date

Section 4. Comments/Follow-up

Comments:

Investigator Name

Agency

Phone Number **Date**